

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2017
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2017
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, ATHENS			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 FRYE ST ATHENS, TN 37303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000			
F 371 SS=F	<p>A recertification survey and investigation of complaint # 40787 was completed on 11/1/17 at NHC Healthcare, Athens. No health deficiencies were cited in relation to the complaint under 42 CFR Part 483, Requirements for Long Term Care.</p> <p>483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to store beverages in a</p>	F 371	<p>This Plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of NHC HealthCare, Athens as to the accuracy of the Surveyors' findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p>F 371 SS=F See next page...</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE

NHA

11-10-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, ATHENS			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 FRYE ST ATHENS, TN 37303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 1 sanitary manner, and failed to maintain dietary equipment, in a clean and sanitary manner in 1 of 2 dietary observations made affecting 63 of 68 residents. The findings included: Review of a facility policy, "Safety & Sanitation Best Practice Guidelines Sanitation Manual Ware Washing" revised 1/2011, revealed "...Remove all traces of food...utensils...shall be cleaned and sanitized...throughout the day at a frequency necessary to prevent recontamination of equipment and utensils..." Review of a facility policy, "Safety & Sanitation Best Practice Guidelines Cleaning Procedures" revised 1/2011, revealed "...Cleaning procedures...Ovens...Scrape burned particles from hearth, brush out interior...Mixer...Clean mixer beater shaft..." Review of a facility policy "Safety & Sanitation Best Practice Guidelines Sanitation Machine Washing" revised 1/2011, revealed "...Check the machine for cleanliness and clean at least once each day or more often...Use an acid cleaner on the machine at least once a week..." Review of a facility policy "Safety & Sanitation Best Practice Guidelines Sanitation Refrigerator and Freezer Storage" revised 1/2011, revealed "...To prevent cross-contamination, partner (facility employee) and patient personal food items may not be stored in refrigerator/freezer in Dietary..." Observation/Interview with the Assistant Dietary Manager on 10/30/17 at 9:40 AM, in the kitchen,	F 371	F371 SS=F Food is always prepared and served in a safe and sanitary manner at NHC Athens. At no time were the patients at risk nor were any negative outcomes noted as a result of the survey deficiencies. The following corrective action will be taken to ensure continued compliance with food service standards. Corrective Action: 1. When reported, the mixer was cleaned on October 30 th , 2017. 2. When reported, the can opener was cleaned and sanitized on October 30 th , 2017. 3. When reported, the oven was cleaned on October 30 th , 2017. 4. When reported, the microwave was cleaned on sanitized on October 30 th , 2017. 5. When reported, the pans in question were cleaned and sanitized on October 30 th , 2017. 6. When reported, the knife was removed from the kitchen on October 30 th , 2017. 7. When reported, the dish machine was cleaned and sanitized with appropriate chemicals on October 30 th , 2017. 8. When reported, the beverage located in the reach in cooler was removed and thrown away on October 30 th 2017.	10/30/17 10/30/17 10/30/17 10/30/17 10/30/17 10/30/17 10/30/17	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 446099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2017
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, ATHENS			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 FRYE ST ATHENS, TN 37303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 2 revealed A. A mixer with dried debris on the beater shaft B. A can opener with dried debris on the base, and under the blade C. Dried burnt debris on the interior bottom, sides, and doors in 1 of 2 ovens observed D. A microwave with dried flaky debris on the interior top Further observation in the kitchen revealed A. 4 of 8 ¼ pans and 1 of 2 baking pans with flaky debris on the rims and inside B. 1 of 8 knives with dried orange colored debris on the blade Interview confirmed all items were available for use. Observation with the Assistant Dietary Manager on 10/30/17 at 9:55 AM, in the dish room, revealed the dish machine with thick dried debris on the door, sides, and top of the machine. Observation with the Assistant Dietary Manager on 10/30/17 at 10:00 AM, in the kitchen, of a reach in cooler revealed an employee's personal beverage stored with patient beverages. Interview with the Assistant Dietary Manager on 10/30/17 at 10:05 AM, in the kitchen, confirmed the facility failed to maintain a sanitary environment in the kitchen and failed to follow facility policy.	F 371	Identifying Other Patients: 1. All Residents had the potential to be affected, however, no Residents were identified during the survey process as being affected. Measures & Changes to be Taken 1. Sheet pans, muffin pans, and service pans, that had flaky debris buildup as a result of dishwashing equipment have been addressed in the following manner; the dish machine is to be de-limed once per week. New sheet pans, muffin pans and service pans have been ordered to replace any older pans with buildup. Completed by Nov 22 nd , 2017. (F371 continued on next page)	11/22/17	

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/01/2017
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, ATHENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 FRYE ST ATHENS, TN 37303			
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N 000	Initial Comments An annual Licensure survey and Investigation of complaint # 40787 conducted on 10/30/17-11/1/17 at NHC Healthcare, Athens, no health deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	F371 Continued 2. An in-service will be held on or before November 17 th , 2017, to ensure Food and Nutritional Service partners are aware of the need for attention to detail and NHC quality standards. 3. An in-service will be held on or before November 17 th , 2017 to ensure Food and Nutritional Service partners are aware to not store personnel items with patient food items. Monitoring Performance: 1. The Dietary Manager or designee will do a QA Study weekly x 8 to ensure all service items are cleaned, sanitized, and stored in proper manner to maintain our Quality of Excellence in dining. Results will be reported monthly to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 8 week monitoring, QA frequency may be reduced depending on results. (See Next Page)	11/13/17 11/17/17	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER'S REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

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11-10-17

If continuation sheet 1 of 1